

Child Death Overview Panel (CDOP) Terms of Reference **2025**



Terms of Reference for LLR Child Death Overview Panel

These terms of reference apply to the Child Death Overview Panel for Leicester, Leicestershire & Rutland. The Leicester, Leicestershire & Rutland Child Death Overview Panel has been set up by the Child Death Review Partners (Leicester City Council, Leicestershire County Council, Rutland County Council, and the Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) to review the deaths of children under the requirements of the Children's Act, 2004 in accordance with *Working Together to Safeguard Children* (2023) & Child Death Review Statutory & Operational Guidance (England) 2018.

1. Key functions

The key functions of the LLR CDOP are to:

- Review all deaths (excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law) of all children usually resident in the area (and where appropriate as agreed by CDR Partners the deaths of non-resident children) irrespective of their place of death.
- Identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified.
- Determine if there were modifiable factors which may have contributed to the death.
- Identify patterns or trends in local data and reporting these to the CDR Partners via an annual report;
- Identify and share learning across agencies;
- Identify and advocate for needed changes in legislation, policy and practices, or public awareness, to promote child health and safety and to prevent child deaths.

2. Objectives

2.1 Notification and data collection

The CDOP will seek to do the following:

- Ensure the accurate identification and uniform consistent reporting of the cause and manner of every child death.
- Collect and collate an agreed minimum data set of information on all child deaths in the area in accordance with Child Death Review Statutory and Operational Guidance (England) 2018, and where relevant, to seek additional information from professionals and family members.
- Ensure that these information gathering processes minimise distress to families.
- Ensure, in consultation with the local Coroner's office, that local procedures and protocols are developed, implemented and monitored, in line with the guidance in *Working Together on enquiring into deaths requiring a Joint Agency Response*.
- Engage with regional and national initiatives to identify lessons on the prevention of child deaths (e.g., East Midlands Regional CDOP Network).
To provide specified data to the National Child Mortality Database.

2.2 Case level

The CDOP will seek to:

- Analyse the information obtained, including the consolidated Reporting form and Draft Analysis form from the Child Death Review Meeting, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths.
- Notify the Case Review Groups of the two Safeguarding Childrens' Partnerships and Local Safeguarding Partners when it suspects that a child has died and may have been abused or neglected.
- Notify the Medical Examiner and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;
- Ensure that families have an allocated Key Worker, who can ensure the family voice is represented in meetings, and where requested by the family, provide sensitive and timely feedback to the family.
- Establish mechanisms for appropriately informing and involving parents and other family members in the child death review process.

2.3 Population level prevention and advocacy

The CDOP will seek to:

- Make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;
- To contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.
- Evaluate data on the deaths of all children normally resident in the local areas, thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.
- To produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learned, and actions taken, and the effectiveness of the wider child death review process.
- Identify any public health issues and consider with the Directors of Public Health, and other professional agencies, on how best to address these and their implications for both the provision of services and for training.
- Identify and advocate for needed change in legislation, policy and practices to promote child health and safety and to prevent child deaths.
- Increase public awareness and advocacy for the issues that affect the health and safety of children.
- Work collaboratively across the system on topics relevant to reducing child mortality with other groups including for example the LLR LeDeR Programme, and the LLR Healthy Pregnancy, Birth & Babies Strategy Group.

2.4 Service review and improvement

The CDOP will seek to:

- Improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each death of a child seeking assurance that relevant agency has provided professionals concerned with feedback.
- Seek assurance that the needs of the family in terms of follow up and bereavement support, have been met.
- Encourage and facilitate contribution of parents and family members to the review process with a view to informing the panel as to the services and support received by the child and their family and any recommendations that could be made to advocate for improvements in this area, as well as to highlight and promote good practice by professionals.
- Seek to understand the experience of the child and family and highlight the voice of the child.

3. Scope

The CDOP will gather and assess data on the deaths of all children and young people from birth (excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law - Abortion Act 1967) up to the age of 17 years 364 days old who are normally resident in the local area. Where a child, normally resident in another area, dies within LLR, that death shall be notified to the relevant CDOP in the child's area of residence. Similarly, when a child normally resident in this area dies outside LLR, the LLR CDOP office will be notified.

In both cases, an agreement should be made as to which CDOP (normally that of the child's area of residence) will review the child's death. In both cases, an agreement should be made as to how the two CDOPs will report to each other.

4. The role of CDOP members

Members of the panel have been appointed to panel in order to bring specific areas of knowledge and expertise to the review process. In addition, they will act as a conduit for ensuring information is disseminated and actions are progressed within their organisation/agency as required.

The following professionals can offer specific contributions to the panel;

4.1 The role of Public Health representative(s) is to:

- Provide the panel with information on epidemiological and health surveillance data.
- Assist the panel in strategies for data collection and analysis.
- Assist the panel in evaluating patterns and trends in relation to child deaths and in learning lessons for preventive work.
- Inform the panel of public health initiatives to support child health.
- Advise the panel on the development and implementation of public health prevention activities and programmes.

4.2 The role of the Acute and Community Health representative(s) is to:

- Help the panel interpret medical information relating to the child's death including offering opinions on medical evidence, provide a medical explanation and interpretation of the circumstances surrounding a child's death.
- Assist with interpreting the post-mortem findings and results of medical investigations.
- Advise the panel on medical issues including child injuries and causes of child deaths, medical terminology, concepts and practices.
- Provide feedback and signposting to support for medical practitioners and allied health professionals involved in individual case management.
- Liaise with other health professionals and agencies.

4.3 The role of the Police representative(s) is to:

- Provide the panel with information on the status of any criminal investigation.
- Provide the panel with information on the criminal histories of family members and suspects.
- Identify cases that may require a further police investigation.
- Provide the panel with expertise on law enforcement practices, including investigations, interviews and evidence collection.
- Help the panel evaluate any issues of public risk arising out of the review of individual's deaths.
- Liaise with other police departments, the Crown Prosecution Service and the local Coroner.
- Provide feedback to police officers involved in individual case management.

4.4 The role of the Children's Social Care representative(s) is to:

- Help the panel to evaluate issues relating to the family and social environment and circumstances surrounding the death.
- Advise the panel on children's rights and welfare, and on appropriate legislation and guidance relating to children.
- Identify cases that may require a further child protection investigation, or a Safeguarding Practice Review.
- Liaise with other local authority services.
- Provide feedback to social workers and other local authority staff involved in individual case management.

4.5 The role of the Integrated Care Board representative(s) is to:

- Provide information from a commissioning perspective (relevant to the cases being discussed), with regard to the local health economy and service provision.
- Provide safeguarding information and guidance as required.
- Identify cases that may require a further child protection investigation, or a child safeguarding practice review.

4.6 The role of the CDOP Chair is to:

- Chair the CDOP meetings, encouraging all team members to participate appropriately.
- Ensure that all statutory requirements are met.
- Maintain a focus on preventive work.
- Ensure that members are clear about their role and facilitating resolution of panel disputes.
- Ensure that the CDOP process operates effectively.
Ensure the submission of the annual report to the LLR Child Death Review Partners.

4.7 The role of the Designated Doctor for Child Death is to:

- Be informed of all child deaths & review relevant case information.
- Chair meetings to ensure all relevant information has been gathered.
- Prepare and present cases for review at panel in collaboration with CDR Nurses.
- Provide the panel with information on the health of the child and other family members, including any general health issues, child development and health services provided to the child or family.
- Help the panel interpret medical information relating to the child's death including offering opinions on medical evidence, provide a medical explanation and provide an interpretation of the circumstances surrounding a child's death.
- Interpret the post-mortem findings and results of medical investigations.
- Provide feedback and signposting to support for medical practitioners involved in individual case management.
- Liaise with other health professionals and agencies.
- Liaise regularly with other Designated Doctors and CDOPs both nationally and regionally.
- Provide feedback to parents where appropriate.
- Work with the CDOP Chair to compile Annual reports and local thematic reports.

4.9 The role of the CDOP Administrator is to:

- Determine meeting dates and send notices to Panel members;
- Prepare and circulate papers for distribution at each meeting and take and circulate minutes.
- Ensure that all CDOP members, ad hoc members and observers sign a confidentiality agreement.

4.10 Current members of LLR CDOP

Core members must be senior representatives from each organisation and have responsibility to advise their organisations on implementation of local procedures to respond to child deaths & implement any actions arising following CDOP review. The Panel has a fixed core membership drawn from key agencies across LLR; however, they have the flexibility to co-opt other professionals to become Panel members on a case by case basis.

Designation	Representing
CDOP Chair	Leicester, Leicestershire & Rutland CDOP
CDOP Deputy Chair	LLR ICB Safeguarding team
Designated Doctor for Child Deaths	Leicester, Leicestershire & Rutland CDOP
Lay Member	
Child Death Review Nurse	Leicester, Leicestershire & Rutland CDOP
Child Death Review Nurse	Leicester, Leicestershire & Rutland CDOP
Detective Inspector – Child Abuse Investigation Unit	Leicestershire Police
Head of Service for Safeguarding & Quality Assurance for Children Services	Leicestershire County Council
Service Manager, Safeguarding Unit	Leicester City Council
Service Manager, Childrens	Rutland County Council
Consultant Neonatologist	University Hospitals Leicester
Consultant Obstetrician	University Hospitals Leicester
Consultant Paediatric Intensive Care	University Hospitals Leicester
Children’s A & E Consultant & Paediatrics	University Hospitals Leicester
Head of Outcomes & Effectiveness, Learning from Deaths	University Hospitals Leicester
Head of Nursing	Children’s Hospital, University Hospitals of Leicester
Consultant in Public Health	Leicestershire County Council
Designated Nurse Safeguarding Children & Adults	Leicester City. Leicestershire & Rutland Integrated Care Boards
Deputy Head of Nursing	FYPC, Leicestershire Partnership Trust
CAMHS Consultant	Leicestershire Partnership Trust
Named GP for safeguarding children	LLR ICB Safeguarding team
Clinical Lead	Leader Program, FYPC
Divisional Senior Manager- Quality	East Midlands Ambulance Service

Ad Hoc Members

Professionals can be co-opted to attend as required.

Representation from the LLR LeDeR Programme will be requested for those panels when the deaths of children & young people with a Learning Disability are being reviewed.

In attendance

CDOP Administrator

5. Meeting arrangements

5.1 Frequency

Meetings will be held at least every 8 weeks and will be administered by the CDOP office. In order for the panel to run effectively and met its objectives, all members are required read the papers ahead of the meeting and notify the CDOP Administrator if there are areas of concern.

The DDCD, CDOP Chair will oversee process for conducting thematic panels.

5.2 Chairing arrangement

The Panel will be chaired by a Public Health Consultant. The Vice Chair may be a representative from Public Health, ICB or Social Care. The chair and vice-chair will be selected by the CDOP members and agreed annually.

5.3 Quoracy

The Child Death Overview Panel will be quorate if there are five or more core members present at the meeting and must include attendance by lead professionals from three organisations (including health and the local authority). The final decision will be made by the CDOP Chair.

5.4 Attendance

In order to ensure the effectiveness of meetings panel members are requested to;

- Inform the Chair in advance if they are unable to attend.
 - Members may request a deputy to attend on their behalf but must ensure that their deputy is briefed on their responsibilities and is able to respond and act on behalf of their organisation. This then needs to be agreed by the CDOP Chair.
- Read panel papers (even if unable to attend) and forward any comments to the CDOP Administrator ahead of the meeting.

If a meeting is not quorate, the Chair can request that the meeting still take place and defer any issues requiring (quorate) decisions to be deferred.

If a CDOP member is unable to attend a meeting, apologies must be sent, or a representative should attend in their place. If a second consecutive meeting is missed, with no apologies, the Chair will write to the senior person of that agency seeking a replacement.

The Designated Doctor for Child Deaths is required to attend all Panel meetings.

6. Confidentiality and Information Sharing

All information discussed at the Child Death Overview Panel is STRICTLY CONFIDENTIAL and must not be disclosed to third parties, without discussion and agreement of the Chair.

Information shared prior to and discussed at the CDOP meetings will be referenced by the child/young person's first name only; all other individuals will be anonymised. Information is shared in the public interest for the purposes set out in 'Working Together to Safeguard Children (2023)' and is bound by legislation on data protection.

The Chair will remind CDOP members of the need to maintain confidentiality at the beginning of each panel.

Any minutes and recommendations arising from a CDOP meeting will be fully anonymised and steps taken to ensure that no personal information can be identified.

7. Accountability and Reporting Arrangements

7.1 Accountability

LLR CDOP is accountable jointly to the LLR Child Death Review Partners (who are the LLR Integrated Care Board and the three Local Authorities):

1. The Directors of Public Health for Leicester City Council and Leicestershire & Rutland County Council; and
2. The ICB Executive Partnership.

7.2 Reporting

LLR CDOP will provide an annual report to the LLR Child Death Review Partners summarising learning and any relevant recommendations for actions for relevant agencies and organisations across LLR. The report will be published on the CDOP webpages and will be disseminated to all relevant agencies which will always include the LSCPBs, Health and Wellbeing Boards, Directors of Public Health and Directors of Childrens Services.

The LLR Child Death Review team will provide quarterly Case Progression Reports to the CDOP Chair, Vice Chair, and three Local Authority Panel Representatives.

8. Conflict Resolution

The CDOP chair should encourage panel members to form a consensus in their assessment and analysis of child deaths. In the event of a disagreement, a vote of members will be taken. In the event of a failure to resolve the issue, the Chair will have the casting vote or discuss with the Vice Chair and Designated Doctor a resolution of outstanding issues.

9. Escalation process

Any actions resulting from CDOP panel will be assigned to the relevant agency via that agency representative on the panel. In the event of actions outstanding, and if deemed appropriate by the CDOP chair, actions will be escalated accordingly:

UHL

Stage 1: UHL Head of Outcomes & Effectiveness

Stage 2: Medical Director

LPT

Stage 1: Deputy Head of Nursing, FYPC

Stage 2: Medical Director

ICB

Stage 1: CDOP Panel Representative

Stage 2: ICB Director of Nursing and Quality

Leicester City Council

Stage 1: CDOP Panel Representative

Stage 2: Director of Public Health

Leicestershire County Council

Stage 1: CDOP Panel Representative

Stage 2: Director of Public Health

Rutland County Council

Stage 1: CDOP Panel Representative

Stage 2: Deputy Director for Children's Services

Leicestershire Police

Stage 1: Detective Superintendent within Serious Crime with responsibility for child safeguarding

Stage 2: Detective Chief Superintendent within Serious Crime with portfolio for child safeguarding

Actions that remain outstanding having followed the above escalation process will be taken to the Directors of Public Health and Executive Group for the ICB and passed to the Safeguarding Children Partnership Boards for information.

10. Declarations of Interest

Panel members must declare any conflict of interest at the outset of each meeting, prior to the relevant case discussions, and panel members should not lead discussions if they are the named professional with responsibility for the care of the child.

11. Review of the LLR CDOP Terms of Reference
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The Terms of Reference will be reviewed on an annual basis.

